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Supreme Court, U.S.
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No. 96-1849

In the Supreme Court of the United States

OCTOBER TERM, 1996

JOHN H. LARY, JR., PETITIONER

v.

SHIRLEY CHATER, COMMISSIONER OF SOCIAL SECURITY, AND DONNA SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the Secretary's Medicare Part B overpayment determination in this case comports with statutory and due process requirements.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. A1) is unpublished, but the decision is noted at 98 F.3d 1353 (Table). The memorandum opinion and order of the district court (Pet. App. B1-B15) are also unreported.

JURISDICTION

The judgment of the court of appeals was entered on September 16, 1996. A petition for rehearing was denied on November 25, 1996. Pet. App. D1. On February 20, 1997, Justice Kennedy extended the time within which to file a petition for a writ of certiorari to and including March 21, 1997 (Pet. App. E1), and the

petition was filed on that date. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In 1965, the Medicare program was enacted as Title XVIII of the Social Security Act, 42 U.S.C. 1395 *et seq.* Medicare has two components. Part A provides primarily hospital insurance, and Part B provides supplementary medical insurance benefits relating largely to physician services. This case involves only reimbursement of claims under Part B for services supplied by petitioner, a physician.

In administering Part B of the Medicare program, the Health Care Financing Administration (HCFA) in the Department of Health and Human Services (HHS) acts through "carriers." 42 U.S.C. 1395u. As statutory agents for HCFA, those private entities, like Blue Cross and Blue Shield of Alabama in this case, perform a variety of functions, such as determining billing standards and reasonable charges for services. Medicare authorizes reimbursement for "reasonable and necessary" services only. 42 U.S.C. 1395y(a)(1)(A). In this regard, the carrier must monitor the actual charges to Medicare beneficiaries to determine whether, *inter alia*, the physician has billed in excess of the maximum allowable charge or billed for medically unnecessary services. 42 U.S.C. 1395u(j)(1) and (*l*).

When a physician files a request for a Medicare Part B payment, the carrier makes an initial evaluation of the claim. If the claim appears "reasonable" under applicable standards, the carrier determines the amount of benefits to be paid. 42 U.S.C. 1395*l*(a)(1); 42 C.F.R. 405.501 *et seq.* In determining whether a "reasonable charge" for physician ser-

vices has been billed, the carrier generally considers: (1) the actual charge; (2) the physician's customary charge; and (3) the prevailing charge in the locality for similar services. 42 C.F.R. 405.502; see generally 42 U.S.C. 1395u(b)(3). Post-payment audits by carriers are authorized as a check to ensure that only "reasonable and necessary" charges were paid. 42 U.S.C. 1395*l*(a)(1) and (e), 1395u(a); 42 C.F.R. 405.501 *et seq.* A Part B physician must supply whatever medical records the carrier deems necessary and appropriate in such an audit to establish the correctness of the payment made by Medicare. 42 U.S.C. 1395*l*(e). Retroactive corrective adjustments in payments may be made when the initial payment proves inadequate or excessive. 42 U.S.C. 1395x(v)(1)(A)(ii).

A beneficiary or physician who is dissatisfied with a payment determination may seek administrative and judicial review. 42 U.S.C. 1395ff(b). The first level of administrative review is a carrier fair hearing. 53 Fed. Reg. 20,023, 20,024 (1988). The hearing officer has authority to review and, if necessary, correct errors by the carrier in the implementation of the program, but is bound by HHS policies and guidelines. 42 C.F.R. 405.860. If the amount in controversy is greater than $500, then the hearing officer's decision may be appealed to an HHS administrative law judge (ALJ), with additional administrative review available before the HHS Appeals Council. 20 C.F.R. 404.929 *et seq.*, 404.967 *et seq.*, as made applicable to the Medicare Program by 20 C.F.R. 404.900. If a written request for Appeals Council review is not filed within 60 days and the time for filing is not extended, then the Appeals Council will dismiss the case. 20 C.F.R. 404.971. By regulation (20 C.F.R. 404.972), "[t]he dismissal of a request for Appeals Council review is

binding and not subject to further review." In addition, if the claimant does not seek Appeals Council review of an ALJ decision within the time allowed, the ALJ's decision is binding on the claimant on the merits. 20 C.F.R. 404.955(a) and (b). By contrast, if a request for review is timely and the Appeals Council either reviews or declines to review the case, then its decision (or the ALJ's decision, if the Appeals Council denies a timely request for review) constitutes the final administrative decision. 20 C.F.R. 404.981. Judicial review of a final administrative decision must be taken within 60 days after the mailing to him of the decision or within such further time as the Secretary may allow. 42 U.S.C. 1395ff(b)(1) (incorporating 42 U.S.C. 405(g)).

2. Petitioner, a specialist in internal medicine, practices in Huntsville, Alabama. Pet. 5. During fiscal years 1986 and 1988, petitioner supplied services to Medicare patients and then submitted bills to the carrier for payment. Based upon initial determinations, petitioner was paid for those claims as billed. Subsequently, the carrier conducted post-payment audits of those years, which gave rise to the two overpayment determinations at issue here. See Pet. App. B1-B2.

The first overpayment dispute concerns petitioner's practice of billing for both endoscopy procedures and office visits for the same patient on the same day. Pet. App. B2 & n.2. That practice, which was clearly prohibited by carrier policy, resulted in an overpayment of $508.47. *Id.* at B3. The carrier's determination was upheld by a fair hearing officer and subsequently by the ALJ. *Ibid.* The ALJ held that the carrier's authority to develop Medicare guidelines for payment of claims and to determine what evidence

is acceptable to establish "medical necessity" comes from section 5240 of the Program Administration Manual. App., *infra*, 7a-8a.[1] The ALJ found further that carrier policy clearly prohibited double billing for endoscopy and an office visit on the same day. *Id.* at 8a. Since the local practice established by the carrier's policy resulted in the lowest cost, the ALJ agreed with the carrier that the charge for global services rather than two separate charges for those services is the "reasonable cost" for those services, and that petitioner was on notice of that policy. *Ibid.* The ALJ also found that petitioner was not without fault in causing or accepting overcharges because petitioner should have known that double billing for same day services was not reasonable as determined by the carrier. *Id.* at 9a.

The second overpayment dispute, amounting to $4,616.43, largely concerns the prohibited practice of "fragmenting" service codes[2] by, for example, billing

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[1] See Decision of the ALJ re FY 1986, App., *infra*, 1a-11a.

[2] Medical services are classified under medical procedure codes developed by the American Medical Association. See Decision of the ALJ re FY 1988, App., *infra*, 17a. Section 5246.4 of HCFA's Manual states that when the level of service reported on the claim form is not reasonable and necessary (*i.e.*, when it has been determined that a less expensive level of service would have met the patient's medical need, or when a less expensive level of service was actually furnished), reimbursement must be based on the reasonable charge for the less expensive level of service. *Id.* at 17a-18a. Section 3045.1A of the Carriers' Manual prohibits fragmentation of assigned charges made under Medicare Part B. *Id.* at 18a. Other errors found included charging for a higher level of service than was established to be medically necessary by the records. *Id.* at 15a-16a. That is, there were no test results or interpretations of tests to verify that the tests were

for a beneficiary's urinalysis conducted on the same day under multiple subcodes instead of billing once under the global code for that process. App., *infra*, 15a. The carrier's determination was upheld by the fair hearing officer[3] and then by the ALJ. *Id.* at 15a-16a.

Petitioner requested Appeals Council review of the ALJ's decisions in these two disputes well over 60 days after notice of each was mailed to him. Pet. App. B3, B4. Petitioner was notified that his requests for review were untimely and would be dismissed unless he could demonstrate "good cause" for the late filing. *Ibid.* Petitioner responded in conclusory terms that he did not receive timely notice of the ALJ's decision and that his request for review was timely. *Ibid.* He did not specify the date on which he received the ALJ's decision, nor did he submit any postmark evidence. *Id.* at C2, C4. The Appeals Council found that petitioner failed to demonstrate "good cause" and dismissed both requests for review, leaving the ALJ's decisions as the final decisions of the Secretary. *Ibid.*

3. Petitioner then filed this suit in district court under 42 U.S.C. 1395ff(b) (incorporating 42 U.S.C. 405(g)), challenging the Secretary's overpayment determinations on statutory and due process grounds

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indicated or were anything more than routine. *Id.* at 15a. In such instances, the Hearing Officer downgraded the services, with a corresponding reduction in the amount of the insurance payment that was proper. *Id.* at 15a-16a.

[3] When petitioner refused initially to submit any documentation to substantiate his charges, the carrier used a statistical random sample to project an overpayment of $28,729.30. Pet. App. B4. However, after petitioner agreed to cooperate, the overpayment was redetermined on the basis of an analysis of the sample claims under review for that year.

and seeking a refund of amounts recouped by the Secretary. In particular, petitioner questioned the authority of the carrier to conduct a post-payment audit, to rely on its own published policy as to what constitutes a "reasonable charge," and to establish the proof requirements, all without following the notice and comment procedures under the Administrative Procedure Act (APA), 5 U.S.C. 553. Pet. App. B11-B12. Additionally, petitioner challenged the denial of subpoena power and discovery prior to the administrative hearing, and the Appeals Council's dismissal of his requests for review of the ALJ's decisions as untimely. *Id.* at B9-B11. He also challenged the final overpayment determination in the second dispute as a prohibited "penalty" under the Paperwork Reduction Act of 1980, 44 U.S.C. 3501 *et seq.*, because it was based upon an audit of documents the production of which was not specifically authorized pursuant to that Act. Pet. App. B12-B14.

The Secretary moved to dismiss the action for lack of subject matter jurisdiction or for summary judgment, pointing out that judicial review is limited to final decisions of the Secretary (42 U.S.C. 405(g)); that, pursuant to 20 C.F.R. 404.972, the Appeals Council's dismissal of petitioner's request for review as untimely was not a judicially reviewable "final decision" (Pet. App. B6); that, even if the Appeals Council's dismissal were a reviewable final decision, it was based on a proper exercise of discretion; and that, in any case, petitioner's legal challenges to the underlying ALJ decisions were without merit (*id.* at B11, B12, B14).

The district court held that it had jurisdiction to review the Appeals Council's dismissal pursuant to controlling Eleventh Circuit precedent, *Bloodsworth*

v. *Heckler*, 703 F.2d 1233, 1239 (1983). Pet. App. B7. The court determined, however, that the Appeals Council did not abuse its discretion in applying the "good cause" criteria for excusing a failure to meet the deadline for seeking administrative review, set forth in 20 C.F.R. 404.911 (Pet. App. B8), or act arbitrarily or capriciously in denying petitioner's requests for review based on his failure to demonstrate good cause for the delay in filing for review (*id.* at B10). The court upheld as reasonable the Appeals Council's determination that petitioner failed to establish a credible explanation for the untimely filings, in the absence of any evidence of the date petitioner actually received notice. *Ibid.*

On the merits of the ALJ's decisions, which it held to be final agency decisions for purposes of judicial review, the district court granted summary judgment for the Secretary. In particular, the court held that the carrier's post-payment audits were conducted in a manner consistent with the Medicare Act, the APA, and due process requirements (Pet. App. B11-B12); that neither the Social Security Act nor the APA provides for prehearing discovery at the administrative level, and that such an opportunity is normally not available (*id.* at B11); and that petitioner had no right to subpoena the Medicare Carrier's Manual or to subpoena Medicare officials to address petitioner's coding practices in prior unrelated audits (*ibid.*). Additionally, the court rejected petitioner's argument that the carrier policy statements on which the overpayment determinations were made were procedurally defective. It held that such materials constitute "interpret[at]ive rules, general statements of policy, or rules of agency organization, procedure or practice," which are expressly exempt from the

APA's notice and comment requirements. *Id.* at B12 (quoting 5 U.S.C. 553(b)(3)(A)).

Finally, the court rejected petitioner's claim that the Secretary's overpayment determination in the second dispute constituted a prohibited "penalty" under the Paperwork Reduction Act because it was based upon petitioner's failure to produce medical records for which no OMB number had been assigned. Pet. App. B12-B14. Observing that petitioner had no right to any Medicare payment for which he could not document "reasonable cost," the court held that the determination of the amount owing was not a "penalty" but rather a decision concerning the amount of Medicare funds incorrectly paid to petitioner. *Ibid.* The court also upheld the carrier's right to project an overpayment when no documentation on the audited random sample is forthcoming, holding that "HHS has authority to make projections concerning overpayments using a random sampling method when the underlying circumstances do not permit a case by case review. The use of a random sample does not constitute a 'penalty' under the Act." *Id.* at B14.

4. In an unpublished *per curiam* decision, the court of appeals affirmed the district court's order affirming the Secretary's determination that petitioner was overpaid. Pet. App. A1. The court found his arguments based on the APA, the Paperwork Reduction Act, and due process to be without merit, and held that petitioner had waived all other arguments raised on appeal. *Ibid.*

ARGUMENT

The arguments petitioner raises are without merit for the reasons given by both lower courts.[4] The holdings of the court of appeals do not conflict with a decision of this Court or of any other court of appeals, and raise no important question of general

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[4] Because petitioner failed to seek review of the ALJ's decisions within the 60-day period allowed, the district court lacked subject matter jurisdiction over this action. As the district court noted (Pet. App. B6), the Eleventh Circuit in *Bloodsworth* v. *Heckler*, 703 F.2d 1233, 1239 (1983), held that, in the circumstance where a review request to the Appeals Council is dismissed as untimely, the ALJ's decision constitutes the "final agency decision," and it may be reviewed in district court so long as review is sought within 60 days of the Appeals Council's dismissal. The court acknowledged that the Eleventh Circuit is the only circuit holding that the district court has jurisdiction to review an Appeals Council decision dismissing an untimely appeal from an ALJ decision. Pet. App. B7. Seven other circuits have rejected that position. See *Bacon* v. *Sullivan*, 969 F.2d 1517, 1520-1521 (3d Cir. 1992); *Matlock* v. *Sullivan*, 908 F.2d 492, 494 (9th Cir. 1990); *Turner* v. *Bowen*, 862 F.2d 708, 709-710 (8th Cir. 1988); *Harper* v. *Bowen*, 813 F.2d 737, 741 (5th Cir.), cert. denied, 484 U.S. 969 (1987); *Adams* v. *Heckler*, 799 F.2d 131, 133 (4th Cir. 1986); *Dietsch* v. *Schweiker*, 700 F.2d 865, 867 (2d Cir. 1983); *Watters* v. *Harris*, 656 F.2d 234, 238-239 (7th Cir. 1980). Even if a court may review the Appeals Council's dismissal of an appeal as untimely, however, it does not follow that where, as here, the court upholds the Appeals Council's dismissal of the appeal, it may nevertheless go on to review the ALJ's decision on the merits. In that situation, the ALJ's decision is binding on the claimant, see 20 C.F.R. 404.955(a) and (b), and the claimant's procedural default in failing to seek timely Appeals Council review would bar the district court from reviewing the ALJ's decision on the merits.

importance.[5] Accordingly, certiorari is not warranted.

1. Petitioner's due process claims (Pet. 23-24) lack merit. The courts below correctly held that petitioner was not entitled to conduct prehearing discovery at the administrative level (Pet. App. A1, B11)[6] or to introduce testimony of Medicare officials about unrelated medical reviews (*ibid.*). Nothing in either the Medicare Act or the APA provides such rights, *ibid.*; see also *Small* v. *Sullivan*, 820 F. Supp. 1098, 1106 (S.D. Ill. 1992); cf. *Hummel* v. *Heckler*, 736 F.2d 91, 93 (3d Cir. 1984), and no court has held to the contrary.

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[5] Since petitioner obtained judicial review of both ALJ overpayment determinations, the question whether the Appeals Council acted improperly in dismissing petitioner's request for review as untimely is essentially irrelevant. The APA, due process and Paperwork Reduction Act arguments discussed below are the only issues that petitioner preserved for review. Pet. App. A1. Accordingly, all of the other questions presented in the petition should be disregarded. See *Citizens Bank of Maryland* v. *Strumpf*, 116 S. Ct. 286, 290 n.** (1995) (Court will decline to address contentions not raised below).

[6] While the issuance of subpoenas in connection with an ALJ hearing may be appropriate "[w]hen it is reasonably necessary for the full presentation of a case," 20 C.F.R. 404.950(d), petitioner failed to establish such a need here. Petitioner sought to subpoena the Medicare Carrier's Manual, a published document that is readily available to the public. Pet. App. B11. Given petitioner's subsequent reliance on portions of that Manual (see, *e.g.*, Pet. 22), a subpoena clearly was not necessary. Nor was carrier testimony as to "technical coding questions" on unrelated, earlier claims (Pet. 24) relevant to whether petitioner's bill coding on the claims audited here conformed with the carrier's policy.

2. The courts below also correctly rejected petitioner's contention (Pet. 25; see Pet. App. B11) that the "Carrier Bulletins," "periodic publications issued by the carrier" and "payment guidelines" issued by, and relied upon by, the carrier failed to comply with the notice and comment requirements of the APA, 5 U.S.C. 553(b)(3)(A). Pet. App. A1, B11. The APA's publication and notice and comment requirements apply to "substantive rules of general applicability adopted as authorized by law." 5 U.S.C. 552(a)(1)(D). Section 553(b) of the APA requires that an agency publish a notice of proposed rules in the Federal Register for public comment, subject to certain exceptions. 5 U.S.C. 553(b). The APA exempts from its notice and comment requirements "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice." 5 U.S.C. 553(b)(3)(A). "Carrier Bulletins," "periodic publications issued by the carrier," and "payment guidelines" are thus exempt from the APA's notice and comment requirements. See *Shalala* v. *Guernsey Memorial Hosp.*, 514 U.S. 87, 99 (1995); see also *Mile High Therapy Centers, Inc.* v. *Bowen*, 735 F. Supp. 984, 986 (D. Colo. 1988) (HCFA ruling explaining Medicare's use of statistical sampling method for audits and computing overpayments held exempt from APA notice and comment requirements); accord *Chaves County Home Health Services, Inc.* v. *Sullivan*, 732 F. Supp. 188, 191 (D.D.C. 1990), aff'd, 931 F.2d 914, 923 (D.C. Cir. 1991), cert. denied, 502 U.S. 1091 (1992). At the same time, however, those carrier materials do not have the force and effect of law, and they therefore do not bind the ALJ or the

Appeals Council in the adjudication of claims. See *Guernsey Memorial Hosp.*, 514 U.S. at 99.[7]

3. Petitioner's Paperwork Reduction Act (PRA) claim (Pet. 21-23) lacks merit. Petitioner contends that the Secretary's overpayment decision regarding fiscal year 1988 must be set aside as violative of the PRA because it was based on petitioner's failure to produce documents as to which the Secretary failed to obtain a separate OMB control number. Pet. 22. In the absence of a control number for this document request, petitioner argues, the PRA relieved petitioner of any duty to respond to the audit.

While petitioner is correct in asserting that the PRA prohibits penalizing a person "for failing to maintain or provide information to any agency if the information collection request * * * does not display a current control number assigned by the Director [of the Office of Management and Budget]," 44 U.S.C. 3512, the Secretary's overpayment determinations below did not constitute a "penalty." Pet. App. A1, B14. As a physician, petitioner is not required to participate in the Medicare program, but if he does, he is subject to program requirements. As noted above, a physician may bill Medicare only for medically reasonable and necessary services and procedures and must adequately document such medical reason-

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[7] Petitioner relies (Pet. 25) heavily on *Glick* v. *Secretary of Health and Human Services*, 714 F. Supp. 39 (D. Mass. 1989), for the proposition that he was not given adequate notice of the types of documentation necessary to establish that his bills constituted reasonable and necessary costs. *Glick* is distinguishable. In that case, there were no clear documentation requirements for participating psychiatric practitioners. See *id.* at 41. Here, by contrast, documentation requirements were explicit. App., *infra*, 16a-17a.

ableness and necessity. See 42 U.S.C. 1395*l*(e). As petitioner concedes (Pet. 23), the claim form on which he submitted his original bills contained an OMB control number. Petitioner was on notice of his continuing obligation under the Medicare Act to substantiate his claims as required by the carrier. Treating an inadequately documented bill as medically unreasonable or unnecessary for Medicare purposes is not an imposition of a penalty. It is merely a finding that Medicare money was erroneously paid to the physician and must be returned.[8]

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[8] To the extent petitioner complains about the carrier's initial assessment of overpayment, an amount derived by extrapolation from a random sample of claims as to which he refused to subnit any documentation, his contention is without merit. The practice of statistical sampling and extrapolation to determine Medcare overpayments has been upheld by the few courts that have considered the question. See *Mile High Therapy Cente, Inc.* v. *Bowen*, 735 F. Supp. at 986; *Chaves County Home Health Service, Inc.* v. *Sullivan*, 931 F.2d 914, 918-919 (D.C. Cir. 1991) (upholding statistical sampling audits in Medicare Part A), cert. denied, 502 U.S. 1091 (1992); cf. *Illinois Physicans Union* v. *Miller*, 675 F.2d 151, 156 (7th Cir. 1982) (sampling audits to recoup Medicaid overpayments). Petitioner's objection is also moot. Once petitioner acquiesced in an audit, the final overpayment amount was revised to reflect only the amount due on the sample claims after a claim-by-claim adjudication.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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JULY 1997

APPENDIX A

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

DECISION

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	SUPPLEMENTAL MEDICAL INSURANCE BENEFITS
Multiple Beneficiaries (Beneficiaries)	Multiple (HIC #)
Blue Cross and Blue Shield of Alabama (Carrier)	000-49-0156 (Docket Number)

This case is before the undersigned Administrative Law Judge on a request for hearing filed on February 7, 1989. An oral hearing was held on February 20, 1992 in Huntsville, Alabama. The appellant was present at the hearing. Also present was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits as well as testimony given at the hearing.

ISSUES

The issue in this case is whether the appellant has been overpaid by $508.57 for medical services provided

to multiple Medicare beneficiaries between January and June 1987.

DECISION

It is the decision of the undersigned Administrative Law Judge that pursuant to Part B of Title XVIII of the Social Security Act, the carrier correctly determined that the appellant had been overpaid by $508.57. Since the appellant was not without fault in causing or accepting the overpayment, recovery of the overpayment cannot be waived.

EVALUATION

Section 1842(a) of the Social Security Act establishes the carrier's responsibility to audit records and assure that proper reimbursement has been made for medical services. Section 1861(v)(1)(A)(ii) of the Act instructs carriers to make suitable "retroactive corrective adjustments" to payments when necessary.

The appellant is a specialist in internal medicine who practices in Huntsville, Alabama. In a letter dated August 31, 1988, the Medicare carrier, Blue Cross and Blue Shield of Alabama, notified the appellant that it had conducted a postpayment review of claims he submitted for services provided to multiple Medicare beneficiaries between October 1, 1986 and September 30, 1987. An overpayment of $1421.09 was identified and the appellant was instructed to send a check for this amount to the carrier. The carrier found that the appellant had incorrectly been paid for office visits provided on the same dates as endoscopy procedures in contravention of carrier policy. Both the endoscopy procedures and office visits were allowed at the full reasonable charge profile amounts.

Since the Administrative Law Judge cannot consider claims for services provided before January 1, 1987, the request for hearing for claims involving services provided before that date has been dismissed. Claims for 23 beneficiaries are still at issue. The overpayment amount for services provided after January 1, 1987 is $508.57. Since the remaining overpayment amount is over the $500.00 amount in controversy requirement and the claims involve "common issues of fact and law," the claims can be aggregated under Section 1869(b)(2)(B) and the undersigned Administrative Law Judge has jurisdiction to hear the case.

Briefly, the Medicare law and regulations provide reimbursement to Part B enrollees on expenses for covered health services and supplies on the basis of a "reasonable charge" (allowable amount). This "reasonable charge" is determined by the carrier, based on data collected from previous Medicare claim experience whenever possible. The collection process is accomplished by means of a procedure (service) identification coding system and actual charges for those procedures which have been billed to the Medicare program. This code and charge information is compiled during an entire 12 month fiscal year from July 1 through June 30. This data is used to price new claims for services rendered beginning January 1st of the next year.

The Omnibus Budget Reconciliation Act, Public Law 99-509, provides that services rendered by Medicare participating physicians during the period January 1, 1989 through December 31, 1989 are to be priced on claim data received during a 12 month, July 1, 1987 through June 30, 1988, fiscal year period. This legislation also maintained the Social Security Amend-

ments of 1972 which imposed a economic index limit of annual fiscal year increases to prevailing charge data (taken from 1971 claim charges) being the base of measurement for each subsequent annual increase.

When selecting a reasonable charge for a specific service, there must be considered 4 primary sources of charge information:

(1) the provider's median charge for the service during July 1, through June 30 preceding fiscal year period;

(2) the prevailing charge by other physicians of the same specialty in the same region during the same fiscal year period for the same service;

(3) the fiscal year 1973 prevailing charge for the service increased by the Medicare Economic Index (MEI); and

(4) the physician's charge on the claim at hand.

Reasonable, as used in the term "reasonable charge", is strictly defined by the law and regulation, and not subject to interpretation. The reasonable charge, by law, is the *lowest* of the above 4 criteria.

The appellant requested a carrier Fair Hearing on October 23, 1988. The hearing was conducted by telephone on January 4, 1989 and a decision was issued on January 20, 1989. The Hearing Officer upheld the carrier's determination of the overpayment, stating:

> The endoscopy procedure is considered to be surgery. Medicare guidelines do not allow the payment of medical visits in the office on the same day that the provider performs surgery because the surgery fee is considered global in nature and should include the cost of medical visits on the same day. Therefore, the carrier was correct in denying payment for the office visits . . .

The appellant argues that Medicare should cover charges for endoscopy and office visits provided on the same day whenever the charges are for two separate medical conditions and that Medicare should deny payment for the visit only when the office visit charge is for routine pre-operative or post-operative care for the concurrent surgery.

The appellant cites the 1988 Physicians Current Procedural Technology (CPT) coding handbook as supporting his position that an office visit provided on the same day as an endoscopy can be allowed. He believes that the carrier should follow the instructions given in the CPT. Paragraph 3 of the "Surgery Guidelines" section of the CPT states:

> FOLLOW-UP CARE FOR DIAGNOSTIC PROCEDURES, e.g. endoscopy, injection procedures for radiography, includes only that care related to recovery from the diagnostic procedure itself. Care of the condition for which the diagnostic procedure was performed or of other concomitant conditions is not included and may be listed separately.

However, the undersigned notes that the carrier is not required to follow the guidelines in the CPT. The

surgery guidelines are not binding on the carrier but may be useful in processing surgery claims.

The appellant also submitted responses to questions he sent to several other Medicare carriers. He asked whether the carriers follow the CPT, whether they pay for both an endoscopy and an office visit performed on the same day when two diagnoses are listed, and whether they pay for an endoscopy and an office visit performed on the same day when only one diagnosis is listed. Most of the carriers who responded to his inquiry indicated that they would pay for an office visit provided on the same day as an endoscopy. However, several carriers indicated that they would pay for the office visit and the endoscopy only if the claim showed different diagnoses for the two services. One carrier, Blue Cross and Blue Shield of North Dakota, indicated that payment for both the endoscopy and office visit would depend on what endoscopy procedure was billed. These responses indicate that there is some variation in how other carriers pay these claims. In addition, several carriers indicated that they do not strictly follow the CPT guidelines for surgery. Equicor of Tennessee indicated that it has adopted some of the surgical guidelines listed in the CPT. However, in some situations its carrier policy guidelines would differ from the CPT.

Blue Cross and Blue Shield of Alabama's policy regarding this issue was explained in Medicare Bulletins dated May 1982 and January 1984. The Bulletins state that an office visit performed on the same day as surgery will be denied because the surgery fee is considered to be "global" and includes payment for the office visit. Since endoscopy is considered to be a

surgical procedure, no payment can be made for an office visit provided on the same day.

At the hearing before the undersigned, the appellant stated that the carrier will allow payment for an endoscopy and another procedure done on the same day but it will not allow payment for the endoscopy and an office visit. He noted that the office visits were related to different diagnoses and that he documented the services he provided. Also testifying at the hearing was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. She indicated that the allowance for the endoscopy procedure is sufficient to adequately reimburse a physician for an office visit. She noted that this policy was based on carrier guidelines written prior to the dates of service at issue. She indicated that the Health Care Financing Administration (HCFA) gives carriers the right to develop their own guidelines based on the standard of practice in the locality. If HCFA does not state exactly what procedures a carrier must follow, the carrier can develop its own guidelines regarding how claims should be allowed.

The carrier states that its authority to develop medical guidelines for payment for Medicare claims comes from Section 5240 of the Program Administration Manual. Section 5240 of the Program Administration Manual states that carriers retain the authority to determine medical guidelines for payment and to determine what evidence is acceptable to establish medical necessity.

After the reviewing the evidence presented in this case, the undersigned finds that the carrier correctly determined that the appellant has been overpaid by

$508.57 for office visits which should not have been separately paid. Carrier policy clearly states that office visits provided on the same day as surgical procedures, such as an endoscopy, should be denied as being included in the global fee for the surgery. Although, carriers in other jurisdictions may follow different policies on this issue, Blue Cross and Blue Shield of Alabama is not required to follow the guidelines utilized by carriers in other areas. Carrier guidelines are based on medical practice in the *locality*, not on practice in other states or areas. In addition, the carrier also is not bound to follow the surgery guidelines provided in the CPT. As stated above, this publication is not binding on carriers and its guidelines may be subject to local interpretation.

Since the overpayment has been upheld, the issue of whether the appellant was "without fault" in causing or accepting the overpayment must be considered. Section 1870 of the Social Security Act states that repayment of an overpayment cannot be ordered if the provider of services is without fault. Pursuant to Section 1870(c) of the Act, repayment will not be ordered for cases in which repayment would defeat the purposes of Title XVIII of the Act or would be against equity and good conscience.

Section 7100 of the Carriers Manual explains liability for overpayment and states that "once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government." Section 7103 of the Carriers Manual explains physician liability for overpayment. Section 7103 states that a physician is without fault if he or she exercised reasonable care in billing for and accepting the payment. Reasonable care is estab-

lished if: (1) the physician complied with all pertinent regulations, and (2) the physician made full disclosure of all material facts, and (3) on the basis of the information available, including but not limited to the Medicare regulations, the physician had a reasonable basis for assuming that the payment was correct, or if the physician had reason to question the payment, the question was brought promptly to the carrier's attention. Section 7103 Carriers Manual.

Therefore, in order to find that the appellant was without fault, the appellant must show that he complied with all pertinent regulations and instructional materials, made full disclosure of all material facts and had a reasonable basis for assuming that the payments were correct, or if he did not, he brought the improper payments to the attention of the carrier. After a careful examination of the record, the undersigned finds that the appellant was not without fault in causing or accepting the overpayment. The undersigned notes that it is the physician's responsibility to comply with Medicare policies and rules which are published in the Federal Regulations, which the carrier has circulated among the medical community, and which the carrier has given to particular physicians. Carrier policy regarding payment for office visits performed on the same day as an endoscopy has been communicated to physicians in carrier Medicare bulletins. Since the appellant is held to have been aware of this policy and did not bring the overpayments to the attention of the carrier, he cannot be considered to be without fault in the overpayment.

FINDINGS

After a careful consideration of the entire record, including the testimony given at the hearing and additional evidence submitted by the appellant, the Administrative Law Judge finds that:

(1) The appellant, John H. Lary, Jr., M.D., received a total overpayment of $508.57 for medical services provided to 23 Medicare beneficiaries between January 28, 1987 and June 9, 1987.

(2) The appellant was not without fault in causing or accepting the overpayment because he did not comply with Medicare instructions and regulations regarding billing for medical services.

(3) Accordingly, recovery of the overpayment cannot be waived.

DECISION

It is the decision of the undersigned Administrative Law Judge that the appellant was overpaid by $508.57 for medical services provided between January 28, and June 9, 1987. Since the appellant was not without fault in causing or accepting the overpayment, recovery of this amount cannot be waived.

/s/ GEORGE M. JACOBS
GEORGE M. JACOBS
Administrative Law Judge
Office of Hearings and Appeals
P.O. Box 10359
Arlington, VA 22210-9998
Date Mar. 26, 1992

APPENDIX B

DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

DECISION

In the case of	Claim for
John H. Lary, Jr., M.D. (Appellant)	SUPPLEMENTAL MEDICAL INSURANCE BENEFITS
Multiple Beneficiaries (Beneficiaries)	Multiple (HIC #)
Blue Cross and Blue Shield of Alabama (Carrier)	000-40-1076 (Docket Number)

This case is before the undersigned Administrative Law Judge on a request for hearing filed on September 5, 1990. An oral hearing was held on February 20, 1992 in Huntsville, Alabama. The appellant was present at the hearing. Also present was Melissa Kerzic of Blue Cross and Blue Shield of Alabama. The Administrative Law Judge has carefully considered all the documents identified in the record as exhibits as well as testimony given at the hearing.

ISSUES

The issue in this case is whether the appellant has been overpaid by $5616.22 for medical services

provided to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989.

DECISION

It is the decision of the undersigned Administrative Law Judge that the overpayment amount is reduced by $999.79 to $4616.43. The carrier is instructed to refund this amount to the appellant. The remaining overpayment of $4616.43 is upheld. Since the appellant was not without fault in causing or accepting the overpayment, recovery of the remaining overpayment cannot be waived.

EVALUATION

Section 1842(a) of the Social Security Act establishes the carrier's responsibility to audit records and assure that proper reimbursement has been made for medical services. Section 1861(v)(1)(A)(ii) of the Act instructs carriers to make suitable "retroactive corrective adjustments" to payments when necessary.

Health Care Financing Administration (HCFA) Ruling 86-1 indicates that carriers can use statistical sampling to project overpayments to providers when claims are voluminous and reflect a pattern of erroneous billing or overutilization, and when a case-by-case review is not administratively feasible. HCFA Rulings are decisions of the Administrator that serve as precedent final opinions and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare. They are binding on all components, including Administrative Law Judges who hear Medicare appeals (42 CFR 401.108).

The appellant is a specialist in internal medicine who practices in Huntsville, Alabama. In a letter dated January 8, 1990, the Medicare carrier, Blue Cross and Blue Shield of Alabama, notified the appellant that it would be conducting a postpayment review of claims he submitted for services provided to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989. Medical records for a random sample of beneficiaries were requested by the carrier. However, the appellant elected not to comply with this request, indicating that it would be an unduly burdensome task. Consequently, the carrier determined that its recourse in such a case was to declare all payments made on the total universe of claims processed during the review period to be in error and request refund of those payments. On March 12, 1990, the carrier notified the appellant of the results of its review. The carrier's medical staff projected an overpayment of $28,729.30 based on a statistical random sample. The appellant was requested to forward a check for this amount to the carrier.

A carrier Fair Hearing was requested on March 14, 1990. After several postponements, a hearing was conducted on July 2, 1990 in Huntsville, Alabama and a decision was issued on August 3, 1990. At the Hearing, the appellant submitted the medical records for the sample claims that the carrier had previously requested. The Fair Hearing Officer in turn asked the carrier to have its medical staff evaluate the medical records, give its recommendations, and calculate any appropriate adjustments to the overpayment previously determined.

After reviewing the medical records, the carrier Utilization Review Committee recalculated the over-

payment at $5616.22. The carrier provided the Hearing Officer with a revised list of reasons for denying specific services. The most common error found during the second review was fragmentation of CPT codes. For example, the appellant billed for urinalysis procedures provided to the same beneficiary on the same day under procedure codes 81015, 81004 and 81005 when the proper code to bill for urinalysis, (specific gravity, protein, tests for reducing substances for glucose) was 81000. Urine culture and sensitivity tests billed under codes 87086, 87088 and 87184 should have been billed under P7001. Very few of the services were denied for lack of documentation to support medical necessity. Claims for testing of stool samples were incorrectly billed based on the number of specimen cards rather than for the complete test.

Claims billed under procedure code 93000 (routine ECG with at least 12 leads; with interpretation and report) were reduced to 93005 when the reviewers could not find evidence that the appellant had performed the interpretations. The carrier also stated that ECG services Q0020, Q0021 and Q0022 are included in Q0019 and should not be billed separately. Claims for diagnostic tests which were not supported by test results were denied even though the appellant had submitted charge slips for the services. Office visits were reduced to meet the descriptions in the CPT manual. The most noticeable error was billing procedure code 90080 for what appeared to be routine visits.

The Hearing Officer stated in his decision that in accordance with instructions from HCFA, the carrier is required to pay claims under the procedure code

that reflects the lowest cost to the Medicare program. Consequently, the Hearing Officer upheld the carrier's denials or downgrades of services in all cases that failed to conform to this policy. For example, urine culture and sensitivity studies were billed by the appellant under codes 87086, 87088 and 87184, all performed on the same patient on the same day. While, these codes are valid codes, the three services should have been combined under code P7000, which is reimbursable at a lower cost to Medicare. The Hearing Officer noted that all Alabama providers were first notified of the P7000 code for use in billing urine culture and sensitivity studies in Carrier Bulletin #84-28 dated June 1984. Subsequent updates have also included this code. The Hearing Officer noted that the appellant had fragmented charges for urinalysis procedures by billing codes 81015, 81004 and 81005 when 81000 included all of the services provided. The October 1986 issue of Providerfax sent to all Alabama providers, warns providers against fragmenting claims for laboratory tests. The Hearing Officer also stated that Section 3045.1A of the Medicare Part B Carriers Manual prohibits fragmentation of charges.

The Hearing Officer upheld the carrier's decision to downgrade 12 lead ECG services from 93000 to lower levels of service because evidence in the file did not document the medical necessity of the more extensive service. In discussing the lack of copies of the results of certain laboratory tests and the fact that the appellant provided charge slips for the services, the Hearing Officer noted that carrier policy requires all providers to submit copies of the actual test results as verification that the test was conducted. In addition, information contained in the laboratory reports

provides evidence regarding the medical necessity of the services. Charge slips do not allow the carrier to determine whether the services were medically necessary. Therefore, the Hearing Officer held that the carrier had correctly denied payment for these tests.

Accordingly, the Hearing Officer held that carrier policy should be followed regarding the use of correct codes for particular services. Therefore, the Hearing Officer held that the overpayment had been correctly calculated at $5616.22.

In most claims for reimbursement under Medicare Part B, the medical services in question are classified by the physician(s) and later by the carrier under medical procedure codes. These codes were developed by the American Medical Association and are set forth in the 4th edition of Current Procedural Technology (CPT), and in the 1990 Health Care Financing Administration's Common Procedure Coding System (HCPCS).

Section 410.20 of 42 CFR allows payment for physician's services. Section 1862(a)(1)(A) of the Social Security Act states that Medicare will not pay for items or services which "are not reasonable and necessary for the diagnoses or treatment of illness or injury or to improve the functioning of a malformed body member".

Section 5246.4 of the Carriers Manual states that went the level of service reported on the claim is not reasonable and necessary; i.e., when it has been determined that a less expensive level of service would have met the patient's medical need, or when a less expensive level of service was actually furnished,

reimbursement must be based on the reasonable charge for the less expensive level of service. Section 3045.1A of the Carriers Manual prohibits fragmentation of assigned charges made under Medicare Part B.

At the Hearing before the undersigned, the appellant contended that his billing practices were correct and that the Medicare carrier was in error in its determinations regarding the use of particular procedure codes. Specifically, he contended that the carrier had improperly reduced the coding of specific services and had incorrectly determined that certain global codes should have been billed.

The appellant stated that chemical examinations of stool samples (82270) should be paid by the number of samples tested rather than as one complete test. He noted that stool samples may be collected over a period of days but all of the samples may be tested on the same day. Glucose testing was cited as an example of this type of billing. Multiple glucose tests performed on the same day are billed separately. The appellant argues that testing of multiple samples should be billed separately unless Medicare states that only one test performed on the same day can be allowed. The appellant has submitted a letter from Renate Jordan, Coding Coordinator at Huntsville Hospital, dated February 19, 1992. Ms. Jordan states that the fundamental rule of coding, billing for a service for as many times as it is performed, would apply to stool examinations billed under procedure code 82270. Therefore, if stool examinations are performed two or more times in a single day, each performance should be coded separately. However, a carrier "Provider Fax" dated January 1989 contradicts this position and instructs providers to list the

number of services provided when billing occult blood screening under code 82270. Payment of this service by Medicare and Blue Shield is for the "complete test rather than the number of specimen cards returned when the services are medically necessary". Notwithstanding the opinion of Ms. Jordan, who is not associated with Medicare, the undersigned finds that the carrier correctly determined that the stool examinations should have been billed as one complete test rather than based on the number of samples submitted.

Regarding billing for urine cultures, he stated that three separate procedures may be performed, a colony count (87086), bacterial identification (87088) and sensitivity test (87184). He noted that it is very important to identify the bacteria present in the samples in addition to the colony count. The sensitivity test is performed to see what antibiotic should be used. Therefore, he argues that all three codes should be paid. Nevertheless, Ms. Kerzic stated that most physicians bill for these tests under one global fee. There is no code in the CPT for bacterial studies. However, as noted by the Fair Hearing Officer, the carrier notified providers in a 1984 publication that the proper code for these services is P7000.

The appellant states that the carrier incorrectly determined that urinalysis tests should be combined under procedure code 81000 as one complete service. He noted that urinalysis tests may include several different procedures which should be billed separately. Ms. Kerzic testified that procedure code 81000 is a global urinalysis code which includes payment for multiple components. The 1991 HCPCS defines procedure code 81000 as "urinalysis, by regent strips,

any number of components; with microscopy". The undersigned agrees with the carrier's determination that the appellant has fragmented his charges for urinalysis tests. The correct code for these services is 81000 which includes all of the components of the services performed by the appellant. This represents the lowest cost to Medicare.

Ms. Kerzic stated that frequently the appellant did not adequately document the services he billed. In many cases, he used a check list and did not indicate the chief complaint or the symptoms which indicated why he was seeing the patient. In some cases the documentation was so poor that it was impossible to determine what service was actually performed. Rather than denying the service entirely, the carrier downcoded the claim to a lower level of service than was billed. Apparently, Dr. Lary consistently refuses to submit medical records requested by the carrier. However, in reviewing records provided by Dr. Lary prior to the hearing, Ms. Kerzic acknowledged that there was sufficient documentation to justify payment for specified billings for thirteen of the beneficiaries. Reductions in the overpayments made to these beneficiaries total over $390.00. Since the total overpayment was based on projections made from sample claims including services which have now been allowed, Ms. Kerzic agreed that she would have to recalculate the overpayment. In a letter to the undersigned dated February 25, 1992, Ms. Kerzic stated that the revised projected overpayment amount is $4616.43. The undersigned accepts this revised amount and holds that the overpayment is reduced to $4616.43. The appellant was given an additional 15

days to respond to the recalculation of the overpayment.

Following the hearing, the appellant submitted an affidavit dated March 9, 1992 and a brief entitled "Statement of the Case". These two documents have been marked as exhibits and included in the file. However, the undersigned notes that the documents repeat the same arguments which the appellant has presented in previous correspondence and at the Hearing.

The undersigned has determined that the remaining overpayment has been correctly calculated by the carrier based on improper billing and fragmentation of charges. A review of the records and the testimony presented at the hearing reveals that the appellant consistently fragments bills for separate components of tests such as urinalysis and urine cultures when the services should be billed under one global procedure code which includes all components of the tests. There are repeated examples in the record where one or more procedure codes were billed when a different code would have more accurately described the services.

The undersigned notes that the appellant has had a succession of hearings in which he raised the same issues concerning his billing practices. He argues that the Medicare practice for establishing the procedure codes to be allowed is incorrect and that he was justified in billing as he did. As noted by Ms. Kerzic, HCFA gives Medicare carriers the right to develop their own guidelines for billing particular services. These standards must of course be consistent with applicable statutes and regulations and should be

based on standards of practice in the locality. The undersigned finds that the carrier acted within its authority to develop payment guidelines for specific services such as laboratory tests. The provider community has been apprised of these guidelines in periodic publications issued by the carrier.

Since the overpayment has been upheld, the issue of whether the appellant was "without fault" in causing or accepting the overpayment must be considered. Section 1870 of the Social Security Act states that repayment of an overpayment cannot be ordered if the provider of services is without fault. Pursuant to Section 1870(c) of the Act, repayment will not be ordered for cases in which repayment would defeat the purposes of Title XVIII of the Act or would be against equity and good conscience.

Section 7100 of the Carriers Manual explains liability for overpayment and states that "once a determination of overpayment has been made, the amount so determined is a debt owed to the United States Government." Section 7103 of the Carriers Manual explains physician liability for overpayment. Section 7103 states that a physician is without fault if he or she exercised reasonable care in billing for and accepting the payment. Reasonable care is established if: (1) the physician complied with all pertinent regulations, and (2) the physician made full disclosure of all material facts, and (3) on the basis of the information available, including but not limited to the Medicare regulations, the physician had a reasonable basis for assuming that the payment was correct, or if the physician had reason to question the payment, the question was brought promptly to the carrier's attention. Section 7103 Carriers Manual.

Therefore, in order to find that the appellant was without fault, the appellant must show that he complied with all pertinent regulations and instructional materials, made full disclosure of all material facts and had a reasonable basis for assuming that the payments were correct, or if he did not, he brought the improper payments to the attention of the carrier. After a careful examination of the record, the undersigned finds that the appellant was not without fault in causing or accepting the overpayment. The undersigned notes that it is the physician's responsibility to comply with Medicare policies and rules which are published in the Federal Regulations, which the carrier has circulated among the medical community, and which the carrier has given to particular physicians. The appellant has consistently billed for medical services under incorrect procedures codes which resulted in incorrect payments. For example, he has consistently fragmented charges for laboratory tests. The undersigned notes that the carrier has made a concerted effort to educate physicians regarding the correct coding for specific services through Medicare bulletins. However, it is the physician's responsibility to be aware of the current usage for particular procedure codes and the coverage of particular services.

FINDINGS

After a careful consideration of the entire record, including the testimony given at the hearing and additional evidence submitted by the appellant, the Administrative Law Judge finds that:

(1) The appellant, John H. Lary, M.D., provided medical services to multiple Medicare beneficiaries between October 1, 1988 and September 30, 1989.

(2) A carrier postpayment review found that the appellant had been overpaid for these services by $5616.22.

(3) The overpayment amount should be reduced by $999.79 to 4616.43.

(4) The remaining overpayment amount is upheld.

(5) The appellant was not without fault in causing or accepting the overpayment because he did not comply with Medicare instructions and regulations regarding billing for medical services.

(6) Accordingly, recovery of the overpayment cannot be waived.

DECISION

It is the decision of the undersigned Administrative Law Judge that the appellant was overpaid by $4616.43 for medical services provided between October 1, 1988 and September 30, 1989. Since the appellant was not without fault in causing or accepting the overpayment, recovery of this amount cannot be waived.

/s/ GEORGE M. JACOBS
GEORGE M. JACOBS
Administrative Law Judge
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Date Mar. 26, 1992